participatory Study
of
Community Health & Development programme
of
Reaching the unreached
by
G. Kallupatti.

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**Community Health Cell**
*Library and Documentation Unit*
*BANGALORE*

# PARTICIPATORY STUDY

of

# COMMUNITY HEALTH AND DEVELOPMENT PROGRAM

of

# "REACHING THE UNREACHED"

G. Kallupatti,
Madurai District,
Tamil Nadu.

Study Group

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## I. SUMMARY

The Community Health and Development initiative of 'Reaching The Unreached' (RTU) tries to reach people remote to development through health measures. The Goals are to actively involve people and enable them in improving their quality of life.

Sangams (associations) of men and women is the means and the nucleus of all health and development activities in the eight villages this programme addresses. The Community Health and Development programme has gone through a phase of stagnation and re-activation in its evolution.

This study is in response to the need felt by the CHD (to know about their evolution, their present status and pointers to the future to help plan ahead) - to be done by an external resource group. Constrains limit quantitative assessments and the focus in on qualitative and process exploration.

The villages chosen are remote and in need of health and development inputs. Sangams of men and women are operational and function fairly well with limitations due to local circumstances. Village Health Workers are effective in minor-ailment management and are well accepted by the community.

The conclusions of the study point to positive areas of good rapport, credibility and initiative while serving in areas of peoples needs.

Numerous activities with small resources, a focus on curative approaches, problems of sangam dynamics and a need for upgrading Health Education efforts are the drawbacks seen.

Recommendations are for focussed activity, putting more efforts into making the sangams far-sighted, involvement of other departments of RTU in the CHD effort, exploring local and other governmental resources and methods of documentation to help the CHD evolve relevant plans for the future.

## II BACKGROUND

The project 'Reaching The Unreached' (RTU) started in the year 1975 and registered in 1978 at G. Kallupatti, Madurai District; it is an attempt to reach people in the remote, unreached areas. The felt need of medical aid in this place led to the starting of a small base clinic facility and a mobile clinic to surrounding areas. This spread into meeting other needs of the people, such as housing, education, water, foster-families for children, income generation programmes and other social welfare measures.

### 1) ORIGINS

The community health programme started later (in 1982/85) using health as an entry point for overall development of the communities in eight villages of this areas. Two volunteers from RTU initiated a process of community organisation. The programme remained stagnant during 1985-86 when these initiators left, and was restarted in 1987 by the present manager of the Community Health Department (CHD). It began with non-formal education incorporating health messages, and slowly evolved into a community health programme. In course of time this transformed into a Community Health and Development programme, and the department of CH & D came into existence at RTU. Two community organisers have joined this department over the past three years to help the Manager who has been handling this programme single handed.

## 2) GOALS AND OBJECTIVES

The goals of this community health and development program as stated in their progress report are :

TO REACH OUT TO A LARGE NUMBER OF PEOPLE IN DISTANT AND REMOTE VILLAGES AND ENABLE THEM TO IMPROVE THEIR QUALITY AND STANDARD OF LIFE, WITH THEIR ACTIVE INVOLVEMENT, USING HEALTH AS AN ENTRY POINT.

This is aimed at building up of confidence and self-reliance in the villages and to initiate a process of common village development through formation of sangams (associations) of men and women.

# III. PURPOSE OF STUDY

Based on a felt need of the community health department of RTU, the present participatory study was undertaken to find out the qualitative impact of the community health program in the eight villages they work in. This participatory study by an external resource group was to see

a) how the community health program evolved;

b) its present status; and

c) to provide guidelines in planning the future.

It is to be specially noted that this participatory interactive exploration of community health and development activities was intended to facilitate the community health department. Hence, this study focussed on community health and not on other activities of RTU. Since baseline benchmark information was not available, a quantitative evaluation study was not feasible. Therefore a process oriented qualitative exploration study was undertaken with minimal emphasis on statistics, survey data, questionnaire, etc. The available periodical reports containing quantitative data have been reviewed. There were also constraints of time - total time for the study being seven days, divided into two blocks of two days and one of three days.

The present study was not focussed on measuring the health status of the community in quantitative terms, but on the process and relevance of community health and development (to enable people understand the importance of the same to improve their quality of life) and hence the methodology adopted.

## IV. EVOLUTION

To chronologically describe the evolution pattern :

1. The earliest activity was the mobile clinic of R.T.U.

2. While pursuing this activity, eight villages were identified for using mainly community health interventions towards overall development. The criteria for selecting these villages were :

   a) lack of any health or development activity;
   b) remoteness from centres of development activities;
   c) being small (population size) and therefore manageable;
   d) people belonging to predominantly backward and underprivileged sections of society.

   Some of the originally selected villages were dropped from the program and others added on depending on CHD assessments and village dynamics.

3. Formation of local Health Committee and selection of Village Health Worker (VHW).

   Formation of village level health committees was preceded by awareness building for health through street theatre and public meetings. This health committee identified a male health worker who was acceptable to the community. These VHWs from eight villages were trained at RTU for a period of 15 days. During 1985-86 the programme was stagnant due to reasons not clearly identifiable. The male health workers stopped pursuing community health activities. In 1987 when it restarted, female village health workers (VHWs) were selected from each of eight villages and given a similar fifteen day training. Guidance and supervision of these VHWs has been continuous and regular since then.

4. Sangam formation :

   Sangams separately for men and women of the village were formed. These sangams were intended to be the hub of all health and development activity. All adults were invited to join the sangams, and those interested joined the same. Some of these sangams are registered and members contribute a fee for common expenditure.

Sangam members were expected to meet atleast once a month to discuss local issues and to mobilise community support for developmental activities. These sangam activities were facilitated by the CHD to utilize both Governmental and other resources. They were instrumental in initiating activities in health and also other areas like building of roads, provision of water and electricity, running of balwadis, improving transportaion facilities and income generation activities for the community.

## V. METHODOLOGY

The present qualitative approach to evaluation consisted of

a) review of available records;

b) discussion with staff at RTU, and field level functionaries;

c) discussion with members of sangam and non sangam members of the villages;

d) observations during field visits; and

e) eliciting opinion from nearby health care delivery agencies.

An elaboration on the above follows :

a) The records reviewed included the annual reports; reports to funding agencies; reviews of past and future plans; mobile clinic records; records at health centres; village registers; training programmes and their curricula; diaries and registers maintained by field staff;

   - for the type of information and their relevance to ongoing community health activities.

b) Discussions were held at RTU with the Director, Assistant Director, Manager, the two community organisers and staff of medical department of RTU. At the field level, the village health workers, Balwadi teachers and Balwadi staff, Non-formal Education (NFE) animators, traditional birth attendants, and informal focussed discussions with them and the people on their work and attitudes were conducted in a non threatening manner.

c) Sangam members, their office bearers, and non sangam members were also contacted in a similar manner and their views elicited - on CHD and their staff, on sangams and thier functioning - in relation to peoples problems.

d) Visits to the village included studying the conditions of housing, water, sanitation, kitchen gardens, nutrition programs at Balwadis, NFE classes and the quality of rapport between CHD staff and community members.

e) An interaction with the Medical Officer and Medical Superintendent at the nearby referral centre at Batlagundu (Leonard Hospital) consisted of identifying local disease patterns, availability of health care services and patterns of utilisation.

The other components studied were library and health education resource materials, VHW's kit, medical stores and other units of RTU including the medical department in relation to CHD activity.

In addition, the CHD staff participated readily and made available existing documents and also co-operated in processing additional information requested by the study team.

## VI. RESULTS

The results are presented as a situational analysis at the village level and in the various activities of the organisations.

### 1. The Villages

The eight villages where the community health department operates are away from the main road, and relatively inaccessible. The population of these villages ranges between 200 to 700. The villages are in two clusters, with a government health centre near each of the clusters, located at Genguvarpatti and Viralipatti. The Government health workers visit these villages mainly for immunization and family planning activities. Programmes on nutrition are conducted under the Tamilnadu Integrated Nutrition Improvement Programme (TINIP).

In RTU built houses, ventilation is good and there is no-chulhas and is built away from the living rooms. From available data we found that illiteracy is high and ranges between 40 to 95 % with a high drop-out rate noticed after the primary level of education. The occupation of the people is mainly as agricultural labour (seasonal) and marginal farmers and shepherds. Most houses are kutcha houses, with one or two rooms, non-electrified and with no toilets. Even though potable water is available, it is inadequate. Most primary schools are within a distance of 2 Kms. Transport and communications are generally available, but inadequate. Balwadis organised by RTU are functioning where not covered by the Intergrated Child Development Scheme (ICDS). Most villages do not have a community television, commonly seen in other villages in Tamilnadu.

Smoke nuisance in the kitchen since it has smoke less.

Organisational Activities

a) Sangam

The membership of the sangams in relation to the total village population varies between 10 % to 60 % with a higher percentage of women being sangam members compared to men.

The percentage of attendance at meetings :

- in Men's meetings - range 54 - 87 %

- in Women's meetings - range 51 - 100 %

On an average one meeting per month is held in both mens and womens sangams. However, during harvesting and planting seasons, meetings are irregular.

The sangams have been able to mobilise people to avail various facilities through government schemes in areas of income-generation, roads, electricity, water supply, and obtaining of pensions for widows. Sangam leaders are given leadership training at RTU periodically.

It is to be noted that a major contribution of RTU is in the area of providing housing facilities which has generated great interest and attraction among sangam members.

Some specific achievements as per records are :

1986 - Construction of 167 RTU houses } Jagjivan
Borewell - one } Nagar.

1987 - 72 RTU houses at Utchapatti

1988 - Distribution of Goats/ Buffaloes / Sheep - for Income generations;

Establishment of sheep rearing society.

1989 - Total 90 persons benefited from government scheme including 28 pensions for widows/streetlights and water taps/ borewells by RTU/Buffalo loans/Jawahar well-digging loans sanction/Sheep rearing society formation/ Road repairs/Widow daughter's marriage through aid/Community hall construction/formation of prohibition committee against female infanticide/ and Flood control wall construction.

1990 - Bullock and sheep rearing loans/street lights/hut electrification/old age pensions/ Credit Union formation/goats for income generation/tree planting alongside road/road-repair/link roads/shed repair/soakage pits/and threshing floors in the villages.

1991 - Sheep rearing loans/bullock cart loans/loans for petty trades/old age pensions/borewells/water-tank with taps/monthly savings scheme started/threshing floor construction and allotment of house-sites.

Some problems areas:

Apart from minor problems, usually found in human groups, others noted were:

- Leaders becoming corrupt and leading to loss of faith in them;

- Enthusiastic participation from sangams generally peaked when RTU houses were constructed and waned dramatically after the event;

- Internal land and caste factors interfered with sangam activity;

- Traditional caste based elders who managed conflict felt threatened by the new sangam leadership.

b) Village Health Workers (VHWs)

Village Health Workers selected by the Village Health Committee were women, a majority of whom were illiterate. They were given an initial training in community health for 2 weeks. Subsequent refresher courses and clarifications at periodic meetings are continuing.

The VHWs are mainly involved in minor ailment treatment, assisting at RTU's mobile clinic and helping the government health workers in their health activities. They also are expected to visit 5 families a day and conduct health education.

The VHWs are provided with a kit containing medicines for treating minor ailments, which is utilized to treat 20 to 30 cases on an average every month at a subsidized rate. They also utilize traditional herbal remedies quite confidently on their own initiative. They record the vital events of births and deaths with the help of a literate. An honorarium of Rs.100.00 per month is paid to them and this is given either by RTU or sangams.

We observed that the VHW is well accepted and has a good rapport with the community. A review of the curriculum showed that the contents were far too technical and voluminous to be covered in this short period. Record keeping activity is inadequate due to their illiteracy. Being sangam members, they also participate in all other sangam activities, but are considered by the people as mainly health resource.

c) Mobile Clinic

The mobile clinic operators twice a week, in the afternoons, effectively reaching each of the eight villages once a month. The team consists of the CHD Manager, a community organiser, a person from the medical department and the local VHW. They provide curative services to the whole population, with a focus on Ante and Post-natal care.

The records show that they see an average of 60 patients a year per village, including ANC patients and growth monitoring of 40 children. Medicines at a subsidized rate are distributed, and Health Education imparted. The schedules of the mobile clinic are very variable, mainly because of dependence on availability of the van for transport of the team.

The health records are minimal, while their work is encumbered by accounting procedures. The records do not provide a clear picture of disease patterns, but discussions with the team and the local referral centre indicated that the common ailments are diarrhoeas, skin diseases, eye diseases and problems of malnutrition. Tuberculosis and leprosy are two common major problems and these are treated with the help of governmental resources. In cholera epidemics in the past, the CHD has been effective in tackling the problem with government and other agencies.

d) Health Education

In addition to health education given by the VHW and at the mobile clinic in a personalized manner, mass health education programmes are conducted on an average of once a month in each of the villages. This is mainly through film shows and slide shows. Street theatre, puppet shows and drama are occasional events. Health Education also forms a component of the training programmes and other meetings at RTU. Film shows are popular with the people.

Records show that the topics covered include — Cooperation, Family Planning, Sanitation and Hygiene, N.F.E., MCH and Nutrition.

## II. CONCLUSIONS

1. The RTU's CHD Department has established a good rapport with the community as well as the government agencies in areas of health and development.

2. The formation and nurture of sangams has enabled the people to begin to understand their health and development problems and also evolve some solutions.

3. A large number of activities have been initiated in a short span of time inspite of meagre resources. Consequently, there has been a blurring of clarity and focus in their well-meaning efforts.

4. Since the selection of vilages was based on criteria of poverty and under-development, the approaches and activities of RTU-CHD have been predominantly welfare oriented.

5. The enthusiasm of the sangams seems to plummet as soon as their immediate felt needs are met from external agencies. This seems to blunt the potentiality of their initiatives, in using their own resources.

6. Curative efforts still from a major part of the health programme, while in development, 'avenues for tapping available resources are being efficiently explored.

7. Cost-effort-effectiveness of mobile clinic is low.

8. The VHW is well accepted by the people and functions effectively in activities alloted to her. However, her inability to maintain effective records, makes it difficult for the CHD to make quantitative assessments of health parameters.

9. Health Education remains largely an effort of the CHD (with its myraid activities and meagre resources) and has not received the attention it deserves.

## III. RECOMMENDATIONS

To effectively strengthen the ongoing and proposed activities, the following recommendations are made:

### 1. Community Organisation and participation:

Sangams have already been formed. This valuable resource needs to be fostered and strengthened with further training/exposure of staff and sangam leadership. Interactions inbetween RTU sangams and others outside is likely to help this process.

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The large membership precludes intensive study and understanding of local issues. The suggested corrective is the formation of smaller working groups in each sangam to take up specific issues. Planned training for these groups with the help of expertise will be of help.

Mens and Womens sangams need to meet together in addition to individual sangam meets, atleast twice a year reviewing their activities in the interim period and to evolve better courses of combined action.

Practical solutions to problems of meetings during harvesting and plantings seasons are to be evolved. e.g. the executive committee/working groups could attempt to meet, or (if this is found to be impractical) the meetings at these times are suspended and the frequency increased subsequently.

Long term comprehensive planning on all relevant development issues is to be initiated and followed up by the sangams.

Proper documentation and review of past decisions etc., will re-inforce this process.

Mechanisms for comprehensive feed-back at regular intervals on decisions and proposed actions both at RTU and sangam levels needs to be established.

Greater accountability and mechanisms for the same should be fostered by open exchange of information on resources, plans, activities, and achievements between CHD and sangams at their meetings.

Invitation of local government officials to sangam meetings should be encouraged.

2. Appropriate strategies for health and development:

People should be encouraged to utilize government health services more and make them responsive to their needs.

The cost-effort-effectiveness of the mobile clinics can be improved with alternative approaches like decentralization and transfer of medical stores along with reduction of team-size and upgrading of village resources (VHW and TBA) also utilizing government health resources. This can be implemented in a phased manner.

A prospective time-bound study of the mobile clinic component in terms of

- patient utilization of services from within and outside the specified villages;

- hours/personnel/medicine/transport/costs etc., involved; and

- areas of non-clinic activities facilitated, needs to be included in the future plans.

Where local/traditional herbal medicines are being utilized as alternatives, allopathic drugs provided, may be withdrawn in a phased manner. e.g., Benzyl Benzoate replaced with Turmeric/Neem leaves, for scabies treatment.

Explore alternative sources of energy like bio-gas, solar cookers, solar powered street lights, etc.

Development of simplified recording systems tailored to the needs of the community as explained in the annexure.

The VHW/TBA/NFE animators/Balwadi teachers and their equivalents from government health resources are to meet periodically and evolve ways and means of implementing sangam decisions.

3. Community support for health care:

Formation of local working groups on health, consisting of atleast five members each from the mens and womens sangams working together as a team will be an important step.

a) This group will be specially trained to improve health education and will be responsible for monitoring all health activities and also function as an activist group to interact with governmental and other agencies for health.

b) To explore ways and means of making the community self-supporting in terms of finance and other relevant resources.

4. Health integrated with Development:

A health-education component is to be incorporated in all training and other programmes of development both at RTU and at the village level. This is likely to make people more conscious and responsible for their own health.

A contributory health service (CHS) scheme could be linked to income-generation programs. This is intended to promote self-sustenance of health services in the village.

At RTU level, staff from all departments are to be sensitised and oriented towards the importance of C.H. in development and should be encouraged and expected to contribute to C.H. concepts in their areas of work.

As a starting point, the medical department could take responsibility for all curative services, and step into areas of prevention and health promotion in the villages where the community health department is active. All health programs can be jointly planned by these two departments. Similar cooperative efforts can be planned with other departments in their areas of work.

5. Education for Health:

Education for health aims at creating awareness among people of all factors that affect health and promoting positive life-styles towards health. Literacy need not be a pre-requisite for this.

Considering the high levels of illiteracy in the villages, adult and NFE should be strengthened and expanded with health as a major component.

In ongoing Health Education, the village working group should be trained, to take up responsibility in all aspects of health education in the village. Some effort should be made to educate the working group on the elements of communication skills.

6. Involvement of tratitional healers, Dais and indigenous systems:

a) The VHW's knowledge base to be increased.

b) The TBAs in the village to be trained and ANC and PNC made locally sustainable.

c) Practitioners of indigenous systems in the village to be integrated into the community health programme.

d) Promote herbal gardens as part of kitchen/garden scheme.

e) Compile and document local herbs used, indications for use, and their effectivity, etc.

7. CHW / VHW:

The VHW is illiterate. Therefore functional literacy to tackle simple meaningful record keeping/understanding health messages and for better communications is to be undertaken as part of their training. Their training also needs to be simplified to suit their limited role in minor ailment treatment and more efforts put in to preventive and promotive health aspects.

Their job specifications depending on their capabilities and community needs is to be made and their training programme tailored to suit this.

The VHWs skills to be upgraded to meet all local minor ailment needs. A referral system to hospital/health centre to be strengthened in the following:

a) Developing an official liaison between RTU-CHD and government or private referral centres;

b) Enabling the VHW to establish a rapport with the centres of referral; and

c) Upgrade the VHWs knowledge to selecting the appropriate referral centres for specific problems.

## APPENDIX :

Suggestions for simplified, comprehensive, relevant record keeping to enable future planning.

1. A register alloted to each village only for records on health - to be kept at the village, accessible to the CHD and sangam health working group for updating.

2. The first 20 pages of register to be kept aside for indexing, comprehensive record of focussed activity (eg., immunization/ANC/Child births/PNC/Vital events, etc.)

3. One page per family for details eg., names of family members/house no./type of house/illnesses in members (chronic)/sangam membership/facilities availed from sangams etc.

4. Start with families with ANC/PNC/Immunization care. Continue with other sangam members, then non-members, such that over a period of 3 to 6 months, complete village records will be available. This will also form the base-line date much needed for future evaluations and planning.

5. Examples of what is to be recorded:

   a) Village name/address on cover;

   b) Page 1 - map of village (folded sheet can be pasted);

   c) Page 2 to 9 for index of family by name/house number;

   d) Page 10 to 20 for comprehensive records.

   e) Page 21 onwards - individual family records - one page per family.

Immunization records:

| | Dt. of recording | April | May | June | July | etc. |
|---|---|---|---|---|---|---|
| No. of children under years age. | 𝍸 𝍸 𝍸 𝍸 | | | | | |
| No. of children comleted BCG | 𝍸 𝍸 | | | | | |
| No. of children comleted DPT/OPV | | | | | | |
| 1st dose | 𝍸 IIII | | | | | |
| 2nd dose | 𝍸 II | | | | | |
| 3rd dose | 𝍸 | | | | | |

(daily work by VHW-LO)

| | | April | May | June | July | August | etc., |
|---|---|---|---|---|---|---|---|
| No. of children completed Measles vaccine | 𝍸 𝍸 𝍸 | | | | | | |
| No. of children completed 1st booster dose | 𝍸 III | | | | | | |
| No. of children in Balwadi roster/receiving supplementary nutrition, etc. | 𝍸 𝍸 𝍸 III | | | | | | |
| ANC / PNC records from April 1992: | | | | | | | |
| No. of mothers pregnant | 𝍸 | | II | III | II | | |
| No. of mothers received T.T. injection | IIII | | | | | | |
| No. of live births | IIII | | | | | | |
| No. of still births | I | | | | | | |
| Dates of delivery | 22/3 23/4 etc | | | | | | |
| Place of delivery (village/outside) | V/V/O | | VO | OOV | | | |
| Delivery conducted by TBA | ✓✓— | | ✓— | --✓ | | | |
| No. of PNC | 𝍸 | | | | | | |

AND SIMILARLY FOR LOANS/OAPs/VITAL EVENTS, etc.

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